#### FIRST REGULAR SESSION

# [TRULY AGREED TO AND FINALLY PASSED]

### SENATE COMMITTEE SUBSTITUTE FOR

HOUSE COMMITTEE SUBSTITUTE FOR

# **HOUSE BILL NO. 986**

## 97TH GENERAL ASSEMBLY

2218S.05T 2013

### AN ACT

To repeal sections 191.237, 208.053, and 208.146, RSMo, and to enact in lieu thereof six new sections relating to health care services, with an emergency clause for a certain section and an effective date for a certain section.

Be it enacted by the General Assembly of the state of Missouri, as follows:

Section A. Sections 191.237, 208.053, and 208.146, RSMo, are repealed and six new

- 2 sections enacted in lieu thereof, to be known as sections 191.237, 208.053, 208.146, 208.993,
- 3 208.1050, and 376.1900, to read as follows:
  - 191.237. 1. No law or rule promulgated by an agency of the state of Missouri may
- 2 impose a fine or penalty against a health care provider, hospital, or health care system for failing
- 3 to participate in any particular health information organization.
- 2. No health information organization may impose connection fees or recurring connection fees on another health information organization for the purpose of exchanging standards-based clinical summaries for patients or for sharing information of an agency
- 7 of the state of Missouri.
  - **3.** As used in this section, the following terms shall mean:
- 9 (1) "Fine or penalty", any civil or criminal penalty or fine, tax, salary or wage
- 10 withholding, or surcharge established by law or by rule promulgated by a state agency pursuant
- 11 to chapter 536;

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- 12 (2) "Health care system", any public or private entity whose function or purpose is the 13 management of, processing of, or enrollment of individuals for or payment for, in full or in part, 14 health care services or health care data or health care information for its participants;
- 15 (3) "Health information organization", an organization that oversees and governs the 16 exchange of health-related information among organizations according to nationally recognized 17 standards.
- 208.053. 1. The provisions of this section shall be known as the "Low-Wage Trap Elimination Act". In order to more effectively transition persons receiving state-funded child care subsidy benefits under this chapter, the children's division, in conjunction with the department of revenue, shall, subject to appropriations, by January 1, 2013, implement a pilot program in at least one rural county and in at least one urban child care center that serves at least three hundred families, to be called the "Hand-up Program", to allow willing recipients who wish to participate in the program to continue to receive such child care subsidy benefits while sharing in the cost of such benefits through the payment of a premium, as follows:
  - (1) For purposes of this section, "full child care benefits" shall be the full benefits awarded to a recipient based on the income eligibility amount established by the division through the annual appropriations process as of August 28, 2012, to qualify for the benefits and shall not include the transitional child care benefits that are awarded to recipients whose income surpasses the eligibility level for full benefits to continue. The hand-up program shall be voluntary and shall be designed such that a participating recipient will not be faced with a sudden loss of child care benefits should the recipient's income rise above the maximum allowable monthly income for persons to receive full child care benefits as of August 28, 2012. In such instance, the recipient shall be permitted to continue to receive such benefits if the recipient pays a premium, to be paid via a payroll deduction if possible, to be applied only to that portion of the recipient's income above such maximum allowable monthly income for the receipt of full child care benefits as follows:
  - (a) The premium shall be forty-four percent of the recipient's excess adjusted gross income over the maximum allowable monthly income for the applicable family size for the receipt of child care benefits;
  - (b) The premium shall be paid on a monthly basis by the participating recipient, or may be paid on a different periodic basis if through a payroll deduction consistent with the payroll period of the person's employer;
  - (c) The division shall develop a payroll deduction program in conjunction with the department of revenue, and shall promulgate rules for the payment of premiums, through such payroll deduction program or through an alternate method to be determined by the division, owed under the hand-up program; and

- 31 (d) Participating recipients who fail to pay the premium owed shall be removed permanently from the program after sixty days of nonpayment;
  - (2) Subject to the receipt of federal waivers if necessary, participating recipients shall be eligible to receive child care service benefits at income levels all the way up to the level at which a person's premium equals the value of the child care service benefits received by the recipient;
  - (3) Only those recipients who currently receive full child care benefits as of joining the program and who had been receiving full child care service benefits [continuously since on or before August 28, 2012] for a period of at least four months prior to implementation by the division of this program, shall be eligible to participate in the program. Only those recipients who agree to the terms of the hand-up program during a ninety-day sign-up period shall be allowed to participate in the program, pursuant to rules to be promulgated by the division; and
  - (4) A participating recipient shall be allowed to opt out of the program at any time, but such person shall not be allowed to participate in the program a second time.
  - 2. The division shall track the number of participants in the hand-up program, premiums and taxes paid by each participant in the program and the aggregate of such premiums and taxes, as well as the aggregate of those taxes paid on income exceeding the maximum allowable income for receiving full child care benefits outside the hand-up program, and shall issue an annual report to the general assembly by January 1, 2014, and annually on January first thereafter, detailing the effectiveness of the pilot program in encouraging recipients to increase their income levels above the income maximum applicable to each recipient. The report shall also detail the costs of administration and the increased amount of state income tax paid and premiums paid as a result of the program, as well as an analysis of whether the pilot program could be expanded to include other types of benefits including but not limited to food stamps, temporary assistance for needy families, low-income heating assistance, women, infants and children supplemental nutrition program, the state children's health insurance program, and MO HealthNet benefits.
  - 3. The division shall pursue all necessary waivers from the federal government to implement the hand-up program with the goal of allowing participating recipients to receive child care service benefits at income levels all the way up to the level at which a person's premium equals the value of the child care service benefits received by the recipient. If the division is unable to obtain such waivers, the division shall implement the program to the degree possible without such waivers.
  - 4. (1) There is hereby created in the state treasury the "Hand-Up Program Premium Fund" which shall consist of premiums collected under this section. The state treasurer shall be custodian of the fund. In accordance with sections 30.170 and 30.180, the state treasurer may

as other funds are invested. Any interest and moneys earned on such investments shall be credited to the fund. Notwithstanding the provisions of section 33.080 to the contrary, any moneys remaining in the fund at the end of the biennium shall not revert to the credit of the general revenue fund.

- (2) All premiums received under the program shall be deposited in the fund, out of which the cost of administering the hand-up program shall be paid, as well as the necessary payments to the federal government and to the state general revenue fund. Child care benefits provided under the hand-up program shall continue to be paid for as under the existing state child care assistance program.
- 5. After the first year of the program, or sooner if feasible, the cost of administering the program shall be paid out of the premiums received. Any premiums collected exceeding the cost of administering the program shall, if required by federal law, be shared with the federal government and the state general revenue fund in the same proportion that the federal government shares in the cost of funding the child care assistance program with the state.
- 6. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated under this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2012, shall be invalid and void.
  - 7. Pursuant to section 23.253 of the Missouri sunset act:
- (1) The provisions of the new program authorized under this section shall sunset automatically three years after August 28, [2012] **2014**, unless reauthorized by an act of the general assembly; and
- (2) If such program is reauthorized, the program authorized under this section shall sunset automatically six years after the effective date of the reauthorization of this section; and
- 95 (3) This section shall terminate on September first of the calendar year immediately following the calendar year in which the program authorized under this section is sunset.
  - 208.146. 1. The program established under this section shall be known as the "Ticket to Work Health Assurance Program". Subject to appropriations and in accordance with the federal Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA), Public Law 106-170, the medical assistance provided for in section 208.151 may be paid for a person who is employed and who:

- 6 (1) Except for earnings, meets the definition of disabled under the Supplemental Security
  7 Income Program or meets the definition of an employed individual with a medically improved
  8 disability under TWWIIA;
  - (2) Has earned income, as defined in subsection 2 of this section;
  - (3) Meets the asset limits in subsection 3 of this section;
  - (4) Has net income, as defined in subsection 3 of this section, that does not exceed the limit for permanent and totally disabled individuals to receive nonspenddown MO HealthNet under subdivision (24) of subsection 1 of section 208.151; and
  - (5) Has a gross income of two hundred fifty percent or less of the federal poverty level, excluding any earned income of the worker with a disability between two hundred fifty and three hundred percent of the federal poverty level. For purposes of this subdivision, "gross income" includes all income of the person and the person's spouse that would be considered in determining MO HealthNet eligibility for permanent and totally disabled individuals under subdivision (24) of subsection 1 of section 208.151. Individuals with gross incomes in excess of one hundred percent of the federal poverty level shall pay a premium for participation in accordance with subsection 4 of this section.
  - 2. For income to be considered earned income for purposes of this section, the department of social services shall document that Medicare and Social Security taxes are withheld from such income. Self-employed persons shall provide proof of payment of Medicare and Social Security taxes for income to be considered earned.
  - 3. (1) For purposes of determining eligibility under this section, the available asset limit and the definition of available assets shall be the same as those used to determine MO HealthNet eligibility for permanent and totally disabled individuals under subdivision (24) of subsection 1 of section 208.151 except for:
  - (a) Medical savings accounts limited to deposits of earned income and earnings on such income while a participant in the program created under this section with a value not to exceed five thousand dollars per year; and
  - (b) Independent living accounts limited to deposits of earned income and earnings on such income while a participant in the program created under this section with a value not to exceed five thousand dollars per year. For purposes of this section, an "independent living account" means an account established and maintained to provide savings for transportation, housing, home modification, and personal care services and assistive devices associated with such person's disability.
    - (2) To determine net income, the following shall be disregarded:
    - (a) All earned income of the disabled worker;

- 41 (b) The first sixty-five dollars and one-half of the remaining earned income of a 42 nondisabled spouse's earned income;
  - (c) A twenty dollar standard deduction;
- (d) Health insurance premiums;
- (e) A seventy-five dollar a month standard deduction for the disabled worker's dental and optical insurance when the total dental and optical insurance premiums are less than seventy-five dollars;
- 48 (f) All Supplemental Security Income payments, and the first fifty dollars of SSDI 49 payments;
  - (g) A standard deduction for impairment-related employment expenses equal to one-half of the disabled worker's earned income.
  - 4. Any person whose gross income exceeds one hundred percent of the federal poverty level shall pay a premium for participation in the medical assistance provided in this section. Such premium shall be:
  - (1) For a person whose gross income is more than one hundred percent but less than one hundred fifty percent of the federal poverty level, four percent of income at one hundred percent of the federal poverty level;
  - (2) For a person whose gross income equals or exceeds one hundred fifty percent but is less than two hundred percent of the federal poverty level, four percent of income at one hundred fifty percent of the federal poverty level;
  - (3) For a person whose gross income equals or exceeds two hundred percent but less than two hundred fifty percent of the federal poverty level, five percent of income at two hundred percent of the federal poverty level;
  - (4) For a person whose gross income equals or exceeds two hundred fifty percent up to and including three hundred percent of the federal poverty level, six percent of income at two hundred fifty percent of the federal poverty level.
  - 5. Recipients of services through this program shall report any change in income or household size within ten days of the occurrence of such change. An increase in premiums resulting from a reported change in income or household size shall be effective with the next premium invoice that is mailed to a person after due process requirements have been met. A decrease in premiums shall be effective the first day of the month immediately following the month in which the change is reported.
  - 6. If an eligible person's employer offers employer-sponsored health insurance and the department of social services determines that it is more cost effective, such person shall participate in the employer-sponsored insurance. The department shall pay such person's portion

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- of the premiums, co-payments, and any other costs associated with participation in the employersponsored health insurance.
- 78 7. The provisions of this section shall expire [six years after] August 28, [2007] **2019**.
- 208.993. 1. The president pro tempore of the senate and the speaker of the house of representatives may jointly establish a committee to be known as the "Joint Committee on Medicaid Transformation".
  - 2. The committee may study the following:
- 5 (1) Development of methods to prevent fraud and abuse in the MO HealthNet 6 system;
  - (2) Advice on more efficient and cost-effective ways to provide coverage for MO HealthNet participants;
- 9 (3) An evaluation of how coverage for MO HealthNet participants can resemble that of commercially available health plans while complying with federal Medicaid requirements;
  - (4) Possibilities for promoting healthy behavior by encouraging patients to take ownership of their health care and seek early preventative care;
  - (5) Advice on the best manner in which to provide incentives, including a shared risk and savings to health plans and providers to encourage cost-effective delivery of care; and
  - (6) Ways that individuals who currently receive medical care coverage through the MO HealthNet program can transition to obtaining their health coverage through the private sector.
  - 3. If established, the joint committee shall be composed of twelve members. Six members shall be from the senate, with four members appointed by the president pro tempore of the senate, and two members of the minority party appointed by the president pro tempore of the senate with the advice of the minority leader of the senate. Six members shall be from the house of representatives, with four members appointed by the speaker of the house of representatives, and two members of the minority party appointed by the speaker of the house of representatives with the advice of the minority leader of the house of representatives.
    - 4. The provisions of this section shall expire on January 1, 2014.
- 208.1050. 1. There is hereby created in the state treasury the "Missouri Senior Services Protection Fund", which shall consist of money collected under subsection 2 of this section. The state treasurer shall be custodian of the fund. In accordance with sections 30.170 and 30.180, the state treasurer may approve disbursements. The fund shall be a dedicated fund and, upon appropriation, money in the fund shall be used solely for the

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administration of subsection 2 of this section. Notwithstanding the provisions of section 33.080 to the contrary, any moneys remaining in the fund at the end of the biennium shall not revert to the credit of the general revenue fund. The state treasurer shall invest moneys in the fund in the same manner as other funds are invested. Any interest and moneys earned on such investments shall be credited to the fund.

2. The state treasurer shall deposit from moneys that otherwise would have been deposited into the general revenue fund an amount equal to fifty-five million one hundred thousand dollars into the Missouri senior services protection fund. At least one-quarter of such amount shall be deposited on or before July 15, 2013, an additional one-quarter by October 15, 2013, and an additional one-quarter by January 15, 2014. The remaining amount shall be deposited by March 15, 2014. Moneys in the fund shall be allocated for services for low-income seniors and people with disabilities.

### 376.1900. 1. As used in this section, the following terms shall mean:

- (1) "Electronic visit", or "e-Visit", an online electronic medical evaluation and management service completed using a secured web-based or similar electronic-based communications network for a single patient encounter. An electronic visit shall be initiated by a patient or by the guardian of a patient with the health care provider, be completed using a federal Health Insurance Portability and Accountability Act (HIPAA) compliant online connection, and include a permanent record of the electronic visit;
- 8 (2) "Health benefit plan" shall have the same meaning ascribed to it in section 9 376.1350;
- 10 (3) "Health care provider" shall have the same meaning ascribed to it in section 376.1350;
- 12 (4) "Health care service", a service for the diagnosis, prevention, treatment, cure 13 or relief of a physical or mental health condition, illness, injury or disease;
  - (5) "Health carrier" shall have the same meaning ascribed to it in section 376.1350;
- 15 (6) "Telehealth" shall have the same meaning ascribed to it in section 208.670.
  - 2. Each health carrier or health benefit plan that offers or issues health benefit plans which are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2014, shall not deny coverage for a health care service on the basis that the health care service is provided through telehealth if the same service would be covered if provided through face-to-face diagnosis, consultation, or treatment.
  - 3. A health carrier may not exclude an otherwise covered health care service from coverage solely because the service is provided through telehealth rather than face-to-face consultation or contact between a health care provider and a patient.

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- 4. A health carrier shall not be required to reimburse a telehealth provider or a consulting provider for site origination fees or costs for the provision of telehealth services; however, subject to correct coding, a health carrier shall reimburse a health care provider 27 for the diagnosis, consultation, or treatment of an insured or enrollee when the health care service is delivered through telehealth on the same basis that the health carrier covers the service when it is delivered in person.
  - 5. A health care service provided through telehealth shall not be subject to any greater deductible, copayment, or coinsurance amount than would be applicable if the same health care service was provided through face-to-face diagnosis, consultation, or treatment.
  - 6. A health carrier shall not impose upon any person receiving benefits under this section any copayment, coinsurance, or deductible amount, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the policy, contract, or health benefit plan.
  - 7. Nothing in this section shall preclude a health carrier from undertaking utilization review to determine the appropriateness of telehealth as a means of delivering a health care service, provided that the determinations shall be made in the same manner as those regarding the same service when it is delivered in person.
  - 8. A health carrier or health benefit plan may limit coverage for health care services that are provided through telehealth to health care providers that are in a network approved by the plan or the health carrier.
  - 9. Nothing in this section shall be construed to require a health care provider to be physically present with a patient where the patient is located unless the health care provider who is providing health care services by means of telehealth determines that the presence of a health care provider is necessary.
  - 10. The provisions of this section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term major medical policies of six months' or less duration, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.

Section B. Because immediate action is necessary to protect low-income seniors and disabled persons, the enactment of section 208.1050 of this act is deemed necessary for the immediate preservation of the public health, welfare, peace and safety, and is hereby declared

- 4 to be an emergency act within the meaning of the constitution, and the enactment of section
- 5 208.1050 of this act shall be in full force and effect upon its passage and approval.

Section C. The enactment of section 376.1900 of this act shall become effective January

2 1, 2014.

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Speaker of the House	
President Pro Tem of the Senate	
Governor	